Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for CPT code 37799.

   b. The request was received on April 19, 2002.

II. EXHIBITS

1. Requestor, Exhibit 1:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. EOB
   c. Medical Records
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:

   a. TWCC 60 and/or Response to a Request for Dispute Resolution
   b. HCFA's
   c. Audit summaries/EOB
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on June 6, 2002. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on June 7, 2002. The response from the insurance carrier was received in the Division on June 18, 2002. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated May 23, 2002 that… "___ is a Cardiac, Thoracic and Vascular Surgeon who works closely with several Spine Surgeons in the ___. These Orthopedic (an occasionally Neurosurgery) specialists request his participation in spinal procedures that require extensive exposure of the anterior (body) portion of the spinal column. This portion of the operative procedure requires skill, experience and knowledge of techniques involving soft tissue only, major arterial and venous structures, and viscera (solid & hollow) that normally lie intimately along the anterior aspect of the thoracic and lumbosacral spine. Extensive mobilization and retraction of these structures in required… We billed our procedure under CPT Code 37799 (unlisted vascular) since there was not specific code to reflect his operative contribution… The reimbursement on this code has varied; we have appealed inappropriately low payments… Recently, we have had a case filed with the TWCC Medical Dispute, where the procedure performed was an anterior exposure and the judge allowed a total of … On the above name patient… ___ has made no payment. Insurance has stated after my re consideration that proper coding should have been used…"

2. Respondent: The respondent states in the correspondence dated June 18, 2002 that… "…Review of the requester's letter dated 05/23/02 reveals the actual service rendered was 'exposure of the anterior (body) portion of the spinal column' for 'treatment of disease of the spinal column' therefore, the requester was performing services related to the anterior interbody fusion, not a separate vascular service… Referring to the bill submitted for service provided on 10/04/2001 and 12/14/2201, each CPT code is associated with each of the 4 diagnosis codes listed on the bill. No modifiers are appended to any of these codes… The descriptor for 37799 is unlisted procedure, vascular surgery. Although, ___ is a surgeon trained in the spciality of vascular surgery, ___ did not have medical disorders requiring surgical intervention of a vascular nature. CPT Code 37799 is for unlisted vascular surgical services, or vascular surgical interventions that do not have a CPT code descriptor. ___ did not perform a vascular surgical intervention. ___ operative report states, 'Surgeon for the anterior approach is ___ who will dictate the anterior approach separately.' ___ identified the procedure for which the anterior approach was performed to be the anterior fusion… ___ does not indicate that any surgery was performed that was not related to the interbody fusion or that was separately identifiable as a vascular surgery unrelated to the interbody fusion…"

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is October 4, 2001.

2. The operative report indicates that the injured employee underwent a "Thoracolaparotomy for exposure of T12 to L2" on 10/04/01.

3. The respondent denied the requestor's bill as "F-N 'THE MEDICAL FEE GUIDELINE STATES IN THE IMPORTANCE OF PROPER CODING OF SERVICES RENDERED IS ESSENTIAL FOR PROPER REIMBURSEMENT'. THE SERVICE PERFORMED ARE NOT REIMBURSABLE AS BILLED."

4. The requestor submitted a Medical Dispute Resolution Request (TWCC-60) and Table of Disputed Services. The requestor identified CPT codes 37799-62, 37700-51 and 37700-51 as disputed services in which the requestor is seeking medical dispute resolution for date of service 10/04/01.

5. The respondent submitted a response to the dispute which included a copy of the requestor's HCFA-1500. The HCFA-1500 identified the disputed CPT codes without modifiers.

6. The 1996 Medical Fee Guideline, General Instruction Section (VII)(A), states, in part, that "A modifier provides the means by which the report HCP indicates a service or procedure performed that has been altered by some specific circumstance but not changed in its definition or code". The HCFA-1500 did not clearly delineate the modifiers as identified on the Table of Disputed Services. Therefore, reimbursement is not recommended.

The above Findings and Decision are hereby issued this 23rd day of January 2003.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf